Department of Veterans Affairs **VHA HANDBOOK 1660.04**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **June 20, 2008**

VA-DOD DIRECT SHARING AGREEMENTS

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook contains instructions on how to develop Department of Veterans Affairs (VA)-Department of Defense (DOD) sharing agreements.

2. SUMMARY OF MAJOR CHANGES. This revised Handbook incorporates revisions necessary due to changes in Departmental policies, and VHA reorganizations. VA-DOD sharing agreements and VA TRICARE activities have evolved into distinct activities and so these two programs are separated. Significant changes in this Handbook are listed below:

a. Types of DOD beneficiaries eligible for care in VA medical facilities (see Public Law 104-262) are clarified.

b. Veterans Integrated Service Networks' (VISNs) role in developing agreements and VA's TRICARE Regional Office (TRO) Liaisons' responsibilities are stated.

c. The requirement for a disclosure statement when a VA-DOD sharing agreement does not include full costs is eliminated.

d. The standard outpatient and inpatient reimbursement schedules under memoranda of agreement (MOAs) agreed to by both Departments is established. Schedules can be found at: http://vaww.vhaco.va.gov/medshare/Default.htm.

e. It is determined that Indirect Medical Education (IDME) cannot be included as a cost in developing agreements. VA medical centers receive separate funding for education through Veterans Equitable Resource Allocation system (VERA).

f. A description of the awards process for the VA-DOD Joint Incentive Fund (JIF) is provided.

g. A new section describing joint ventures is added.

3. REATED ISSUES. VHA Handbook 1660.05.

4. RESPONSIBLE OFFICE. The VA-DOD Sharing Office (10D2) is responsible for the contents of this Handbook. Questions should be directed to 202-461-6632.

5. RECISSIONS. VHA Handbook 1660.4, dated March 31, 2004, and VHA Directive 2006-046, dated August 17, 2006, are rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for re-certification on or before the last day of June 2013.

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1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines procedures that Department of Veterans Affairs (VA) medical facilities, Veterans Integrated Service Networks (VISNs), and other organizational components need to develop health resources direct sharing agreements with military treatment facilities (MTFs), and other Department of Defense (DOD) organizational components. Components include National Guard and Reserve units.

2. AUTHORITIES

The VA-DOD Health Care Resources Sharing and Emergency Operations Act (Title 38 United States Code (U.S.C) 8111) and Public Law 107-314.

3. SCOPE

VA-DOD sharing activities covered within the scope of this Handbook include: eligibility for care; VA medical center and VISN responsibilities; development of sharing agreements; reimbursement and billing; approval of VA-DOD agreements; construction and equipment; the Joint Incentive Fund (JIF); joint ventures; and education and training agreements.

4. ELIGIBILITY

a. MTFs and other DOD organizational components may provide health care to VA beneficiaries eligible for care under 38 U.S.C. §101 on a referral basis under the auspices of a sharing agreement. VA facilities may provide health care to DOD beneficiaries eligible for care under 10 U.S.C. §1071 *et.seq.* on a referral basis under the auspices of a sharing agreement. Coast Guard active duty servicemembers are not covered under VA-DOD agreements.

b. VA-DOD beneficiaries provided care under an agreement are the responsibility of the party to the agreement that is making the referral of the patient to the other party. All questions regarding financial responsibility for care provided to these beneficiaries may be referred and resolved by the designated officials of the parties to the agreement under which the care is being provided.

5. VA MEDICAL CENTERS' AND VISNS' RESPONSIBILITIES

a. The VA-DOD Sharing Law (38 U.S.C. 8111) gives VA medical facilities and VISNs the flexibility to negotiate sharing agreements covering a broad spectrum of health-related activities. Since prospective agreements may affect health care resources within a VISN, VA medical centers need to consult with VISNs before submitting these agreements to the VA-DOD Sharing Office (10D2) for approval.

b. VISNs or VA Medical Centers may develop agreements. Typically, VISNs develop agreements that cover the entire VISN. VHA Central Office components usually facilitate national agreements.

c. VA's TRICARE Regional Office (TRO) Liaisons responsibilities include:

(1) Interfacing between the VISN or medical center Directors, VHA Central Office, and TROs to assist in developing sharing agreements;

(2) Identifying new areas where economies of scale can be realized;

(3) Serving as VA's primary education link between VISNs and the TROs regarding agreements;

(4) Providing subject matter expertise to MTFs within the region and the military services; and

(5) Participating in the development, analysis, and implementation of long-term and short-term policies for integrating the two health care delivery systems.

6. DEVELOPING AGREEMENTS

a. **Identify Points of Contact.** VA medical facilities and VISNs need to identify individuals to serve as points of contact (POCs) with their DOD counterparts.

b. **Areas of Opportunity.** VA medical facilities or VISNs may enter into VA-DOD agreements covering medical services and other hospital-related activities. Sharing arrangements are never to reduce services or diminish the quality of care for veterans; they are to identify potential services where one or both Departments are paying higher purchased care costs than they would if they built in house capacity. These opportunities may include: inpatient, outpatient, and other ambulatory care services or procedures; ancillary services; telehealthcare; research and development; and training. Non-clinical services areas of opportunity for sharing include, but are not limited to staffing, laundry, and emergency management.

(1) Examples of current services covered in VA-DOD agreements are:

(a) Primary care,

(b) Ambulatory surgery,

(c) Orthotics,

(d) Prosthetics,

(e) Ophthalmology,

(f) Podiatry,

(g) Dialysis,

(h) Audiology,

(i) Otolaryngology,

(j) Radiology,

(k) Radiation therapy,

(l) Substance Abuse,

(m) Post Traumatic Stress Disorder (PTSD)

(n) Research and Development,

(o) Staffing support,

(p) Laundry and linen services,

(q) Infectious and radioactive waste,

(r) Sterilization,

(s) Fire and safety,

(t) Medical and surgical supplies,

(u) Sanitation, and

(v) Transportation.

(2) VISNs wishing to explore the potential for VA-DOD sharing on a local or regional basis, may contact the military services, their MTFs, and their TRO, in coordinating with other VISNs to consider sharing, i.e., to assemble "networks" to encompass large geographic regions. Examples of sharing at a regional level are:

(a) Laboratory services,

(b) Teleradiology and telemedicine services,

(c) Substance abuse treatment services,

(d) Mental health services,

(e) Medical and surgical supplies,

(f) Graduate medical training,

(g) Prosthetics and sensory aids,

(h) Integration of clinics and staffs,

(i) Improvement of integration at joint venture sites, and

(j) Improvement in the coordination of information systems.

c. **Items to be Included in Agreement Discussions.** After potential areas for collaboration have been identified, VISN or medical center staff need to discuss projected costs, workload, and resources with their counterparts at MTFs and their VA TRO Liaison, as appropriate.

d. **Agreement Format**

(1) The VA-DOD Sharing Office (10D2) recommends use of VA Form 10-1245c, VA-Department of Defense Sharing Agreement.

(2) Agreements must detail the resources to be provided, the cost per unit of those resources, the anticipated number of units, and performance and delivery requirements. Agreements start on Block 9 of VA Form 10-1245c, and may be continued on bond paper, depending on the nature and length of an agreement description.

(3) Agreements must include any special arrangements, such as transportation and meals.

e. **Acquiring or Increasing Health Care Resources.** Medical centers and VISNs may consider acquiring or increasing health care resources that exceed the needs of the facility's primary beneficiaries, but that serve the combined needs of both VA and DOD.

(1) Sharing agreements requiring additional capacity must cite the combined workload of the participating facilities. Approval for additional resources must be obtained from the VISN Director before submission of the agreement or contract to the VA-DOD Sharing Office.

(2) If new medical resources are to be obtained by VA, multi-year commitments ordinarily need to be obtained from DOD facilities.

(3) The justification must cite the combined workload of the participating facilities.

(4) "Piggy-back" agreements may be developed that take advantage of the fact that one Department has obtained favorable prices from a vendor.

NOTE: *Supplemental staffing agreements allowing facilities to offer a fuller range of services than could otherwise be provided by utilizing staff from the other Department are encouraged.*

f. **Dental Services**

(1) VA medical care facilities planning to enter into VA-DOD dental sharing agreements need to consult with their Chief of Dental Service to determine whether there is sufficient capacity to enter into an agreement. As with all VA-DOD sharing agreements, VA facilities may not reduce services or diminish the quality of care for veterans.

(2) A cost analysis needs to be performed to ensure that the proposed rate covers the VA medical center's adjusted cost for providing such care, along with a review of pertinent local or regional American Dental Association (ADA) posted rates. The medical center also needs to determine the amount of workload they can provide to DOD beneficiaries.

7. BILLING AND REIMBURSEMENTS

a. VA medical facilities must adhere to standardized uniform payment and reimbursement schedules based upon Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Maximum Allowable Charges (CMAC) for outpatient rates and Diagnoses Related Group (DRG) charges as specified in outpatient and inpatient MOAs agreed to by the two Departments.

(1) Indirect Medical Education (IDME) cannot be included as a cost. VA medical centers receive separate funding for education support through the Veterans Equitable Resource Allocation system (VERA).

(2) Other cost estimation methods may be used for types of services not covered by CMAC, such as space, laundry, and staff support.

(3) Building depreciation, interest on net capital investment and VHA Central Office overhead must be excluded from cost estimates.

(4) Reference laboratory services need to be evaluated using variable technical costs, and each laboratory test must be reviewed against commercial rates to establish cost per test to meet the facilities cost to provide the service. Cost per tests could vary on a discount of the CMAC based on business case analysis.

(5) VA medical centers are responsible for ensuring that:

(a) Each sharing agreement is a valid business arrangement, and

(b) Costs in providing services are covered so that these services do not constitute a subsidy to DOD.

(6) Documentation of the cost analysis performed needs to be included in the agreement's file which must include a description of elements included to develop adjusted costs.

(7) In some cases, agreements are established without reimbursement for "in kind" services, such as Pre-Separation Physicals (Benefits Delivery at Discharge). The reasons reimbursement is not included in the Business Case Analysis must be stated.

b. VA medical facilities must bill or pay for inpatient and outpatient clinical services provided to individuals referred under VA-DOD sharing agreements at the CMAC rate, less 10 percent or the DRG rate less 10 percent. ***NOTE:*** *CMAC rates are located at:* *http://www.tricare.mil/ocfo/mcfs/ubo/mhs_rates/cmac.cfm*

(1) Billing facilities must only bill the net amount after the 10 percent discount.

(2) Paying facilities will pay the net amounts billed in full.

c. Requests for waivers larger or smaller than the discount rate for outpatient services must contain the following information:

(1) VA facility name, and location;

(2) VA POC, i.e., the name, telephone number, and e-mail address;

(3) MTF name and location;

(4) MTF POC, i.e., the name, telephone number, and e-mail address;

(5) Date of request;

(6) Description of waiver and proposed alternative rate;

(7) Reason for waiver request;

(8) Benefits derived (include significant tangible and intangible factors);

(9) Impact if waiver is disapproved;

(10) Calculations used to determine desired the discount, including data source; and

(11) VA Facility Director and MTF Commander signatures.

d. VA facilities must forward waiver requests through the VISN Director to the VA-DOD Sharing Office. The VA-DOD Sharing Office has 5 business days to forward the request to the VA-DOD HEC Financial Work Group (FMWG). The FMWG reviews the request and requests additional information if necessary. The FMWG must provide a decision within 30 calendar days from receipt of all pertinent information.

e. Joint Ventures and exempted co-located facilities may negotiate rates less than CMAC, less 10 percent adjusting the rates to reflect the value of non-monetary contributions, such as shared space or staff. ***NOTE:*** *Consult the VA-DOD Sharing Office for a current list of exempted facilities.*

f. Separate pharmacy rates and service charge fees must be established periodically by the Chief Business Office (16).

g. The Center for Medicare Services (CMS) Health Insurance Claim Form 1500, or Universal Billing (UB) 04s must be used for billing, generally, on a monthly basis. ***NOTE:*** *VA's Financial Services Center strongly recommends use of the Intra-Governmental Payment and Collection (IPAC) system whether sending or receiving payments and collections*.

(1) Quarterly billing is allowable for agreements involving low volume or costs. In agreements where each agency provides some service to the other, each facility must render the other a bill for the gross amount; the facility billing the lesser amount pays the difference. Fourth quarter billing can be separated into the first 2 months to allow for processing and inclusion of funds into the appropriate fiscal year of expenditures, and then September to be reconciled in October.

(2) The medical center must ensure that both reimbursements earned and costs incurred are recorded in the gross amounts, before calculating the difference and the net payment due.

(3) Charges or payments need to be directed to the DOD component entering into the agreement.

(4) All bills must be signed by the appropriate VA official.

(5) VA patient workload performed in an MTF must be captured into the Veterans Health Information System and Technology Architecture (VistA) for workload capture and financial performance indicators.

NOTE: *Billing guidance is provided by the VHA Chief Business Office (16) by request.*

h. The following revenue source codes apply to VA-DOD sharing agreements:

(1) **8014** - Non-medical sharing agreements; e.g., laundry, space, fire and police protection.

(2) **8017** - Sharing agreements for inpatient services; e.g., services which involve an overnight stay.

(3) **8018** - Sharing agreements for outpatient services; e.g., laboratory, physicals, etc.

i. Facilities must initially absorb the cost of providing reimbursable services for sharing agreements except in Joint Incentive Fund (JIF) Projects (see par. 10). JIF projects are required

to culminate with the establishment of a sharing agreement that describes how the project will be sustained after the project ends.

8. APPROVAL OF AGREEMENTS

a. **Approval Process**

(1) The medical center or VISN Director and their DOD counterparts need to sign proposed agreements. Facilities need to inquire with their VISN Coordinator to see if a review of their proposed agreement is necessary. After these signatures have been obtained, the proposed agreement is scanned and submitted electronically only to the Outlook addressee, "VA-DOD Sharing Agreements." The VA-DOD Sharing Office provides the results of the review by e-mail. The VHA officials most responsible for implementing the agreements need to sign national VA-DOD agreements.

(2) The VA-DOD Sharing Office must either approve or disapprove any proposed agreement within 45 days of receipt. If action is not forthcoming at the end of the 45-day period, the agreement is considered approved on the 46th day. The VA-DOD Sharing Office must provide VISNs with copies of all approved local agreements affecting their respective regions.

b. **Renewals.** The VA-DOD Sharing Office must approve renewal proposals for all sharing agreements. Renewals may be written for up to 5 years. Renewals retain the same number with an additional or changed suffix, for example: 2002-FRS-0023 becomes 2002-FRS-0023A.

c. **Amendments.** Amendments to existing agreements must be forwarded to the VA-DOD Sharing Office (10D2) for approval. The same procedures described for initial agreements must be followed for amending agreements.

9. CONSTRUCTION AND EQUIPMENT

a. **Construction.** In accordance with 38 U.S.C. Section 8102, VHA officials must coordinate facilities' construction, alteration, or acquisition plans with their DOD counterparts where VA facilities are located within 50 miles of a MTF and with a total construction expenditure request of $2 million. ***NOTE:*** *Economies of scale lead to more efficient use of Federal facilities at all levels of medical care.* When considering the construction of a new or replacement medical facility, VHA officials must consult with DOD regarding the feasibility of carrying out a joint project to construct a medical facility that:

(1) Could serve as a facility for health-resources sharing between VA and DOD; and

(2) Would be no more costly to each Department to construct and operate than separate facilities for each Department.

b. **Coordination of Equipment Purchases.** VHA facilities must coordinate acquisition of major equipment in excess of $400,000 commensurate with the high-cost equipment ceiling currently in place with MTFs within 50 miles (in accordance with VA Acquisition Regulations

(VAAR) Subpart 817.70). This coordination is to determine if the VA facility or the MTF has similar equipment which can be shared, or if either would be interested in sharing the equipment.

10. JOINT INCENTIVE FUND (JIF)

a. **Background.** Section 721 of Fiscal Year (FY) 2003 National Defense Authorization Act (NDAA) required establishment of a JIF to provide incentives for creating innovative DOD-VA sharing initiatives at the facility, regional, and national levels. DOD and VA contributed $15 million each to the Fund in FY 2004; a similar amount was deposited to the fund at the beginning of each fiscal year through FY 2007, and this has been extended through 2010. The VA-DOD Joint Executive Council (JEC) has delegated the implementation of the fund to the VA-DOD Health Executive Council (HEC). VHA administers the fund under the policy guidance and direction of the HEC.

b. **Submitting Proposals.** A call for JIF proposals is released one to two times a year; these proposals must be jointly developed between the DOD and VA entities, and must meet a business case analysis.

(1) Proposals are submitted through respective Departmental management structures, (Service Surgeon General or VISN). ***NOTE:*** *More detailed instructions are provided in the JIF call letter.*

(2) VA proposals are submitted to the VA-DOD Sharing Office. ***NOTE:*** *Complete information on submitting JIF proposals can be found at:* *http://www.tricare.osd.mil/DVPCO/default.cfm*

(3) After review the VA-DOD Sharing Office forwards the proposal to the Financial Management Work Group (FMWG).

(4) The VA-DOD JEC has final approval authority.

c. **Selection Process.** To expedite the selection process, all proposals must include a business case analysis and official certification by the Service and VISN or Chief Officer that the proposal will be either self-financing, have no recurring costs, or that recurring costs will be funded within existing budgets after JIF funding ends.

11. JOINT VENTURES

a. **Defined.** Joint ventures, established in accordance with VA policy, are characterized by specific resource sharing agreements encompassing multiple services resulting in joint operations.

(1) These arrangements resemble strategic alliances between DOD and VA for the purposes of long-term commitments of more than 5 years to facilitate comprehensive cooperation, shared risk, and mutual benefit. They may or may not involve joint capital planning and coordinated use of existing or planned facilities.

(2) Joint ventures exist along a continuum in which the medical facility missions and operations are connected, integrated, or consolidated. They are characterized by regular and ongoing interaction in one or more of the following areas: staffing, clinical workload, business processes, management, information technology, logistics, education and training, and research capabilities.

b. **Impact on VA Construction.** All proposed joint ventures involving construction contract documents must be forwarded to the Director, Office of Construction and Facilities Management for review.

12. EDUCATION AND TRAINING

a. **Scope**

(1) Agreements may be developed for military units and individuals (including Reserve and National Guard) receiving training and education at VA facilities, as part of their reserve assignments, provided no educational institution is involved and no academic credit is awarded.

(2) Students from a military-sponsored academic institution, such as from state-approved and accredited schools of practical nursing, medical technologists programs, and schools of nurse anesthesia, must use a Memorandum of Affiliation provided by VA's Office of Academic Affiliations, not a VA-DOD agreement. ***NOTE:*** *No VA stipend, fee, or salary may be provided to trainees under VA-DOD agreements*

b. **Training Must Be Integrated in VA Care.** ***NOTE:*** *Agreements covered under this Handbook are only for training that is fully integrated into the VA medical system.*

(1) The Office of Academic Affiliations (14) coordinates medical residents' training involving military medical personnel separately.

(2) Training includes providing direct patient care, use of VA medical center classrooms, on-line courses or additional opportunities coordinated through the Employee Education System (EES).

(a) Satellite programs may be available for viewing by both active duty and Reserve or National Guard medical personnel who are then eligible to receive continuing education credit for licensure through EES.

(b) Training courses may also be broadcast to DOD components throughout the world. Roles of military personnel are limited to those specified in the agreement.

(3) Competency and privileging activities of military personnel in VA medical facilities are under the direct supervision of VA staff designated by the VA medical center Director.

c. **Agreements with No Reimbursements to Either Party.** Education and training agreements with no reimbursement for services delivered are considered to be in effect when

signed by both parties at the local level, unless the parties entering into the agreement have indicated otherwise. Approval from the VA-DOD Sharing Office is not necessary. However, the agreements must be submitted to the VA-DOD Sharing Office in order that a list of active agreements can be maintained.

d. **Responsibilities of the Medical Center Director.** The medical center Director is responsible for:

(1) Retaining full responsibility for patient care and maintaining the administrative and professional supervision of all military personnel insofar as their presence affects the operation of the VA facility.

(2) Reviewing and endorsing the education and training schedule provided by the military unit commander. This review includes:

(a) Verifying the licensure and certification of each active duty, Guard, and Reserve medical personnel for professional and technical qualifications; and

(b) Formal privileging of trainees by the usual VA health care facility mechanisms.

(3) Ensuring that personnel have been informed of applicable rules and regulations with which they are expected to comply.

(4) Requiring the military unit commander to withdraw any DOD person for unsatisfactory performance or behavior.

(5) Requiring the military unit commander to provide the names and qualifications of military supervisors assigned to work with VA staff.

e. **Meals and Quarters.** Under a separate agreement, VA may furnish meals, quarters, laundry services, and, medical wearing apparel for trainees (current VHA policy).

f. **Sharing Agreement Requirements.** Sharing agreements must include the categories of health occupations, the numbers of trainees in each category, and a statement that the responsibilities described in subparagraph 11b have been fulfilled.